REGION I AGING SERVICES

Karen Quick, Regional Aging Services Program Administrator

Serving: Divide, McKenzie & Williams Counties

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AGING SERVICES NEWSLETTER

Please share this newsletter with a friend, coworker, at your Senior Center, post on a bulletin board, etc… If you wish not to be on the mailing list for the newsletter, please contact **Karen Quick** at **774-4685 or 1-800-231-7724**. You are welcome to submit any news you may have regarding services and activities that are of interest to seniors in this region **Northwest Human Service Center** makes available all services and assistance without regard to race, color, national origin, religion, age, sex, or handicap, and is subject to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1975 as amended. **Northwest Human Service Center** is an equal opportunity employer.

MISSION STATEMENT:

In a leadership role, Aging Services will actively advocate for individual life choices and develop quality services in response to the needs of vulnerable adults, persons with physical disabilities, and an aging society in North Dakota.

north dakota department of human services

Medicare Prescription Drug Benefit Update - Bill Lardy, ND Insurance Department

This year, people with Medicare will have the opportunity to enroll in the new Medicare prescription drug benefit. **Every one with a Medicare card is eligible to join this new Medicare Prescription Drug Benefit.** The Medicare drug program is voluntary. Some people with Medicare will have to pay a monthly premium for the benefit as well as deductibles and co-payments. People with limited income and resources may receive help to reduce premiums, deductibles and co-payments. In any case, ***most people can expect to save money on their medicine if they enroll.***

This article is a brief introduction to the prescription drug benefit.

The program is called Medicare Part D

- It is voluntary
- Medicare prescription drug plans provide insurance coverage for prescription drugs
- Medicare prescription drug coverage helps pay for brand name and generic drugs
- Any one on Medicare can enroll in the program beginning November 15, 2005
- There is a monthly premium to join a plan, unless you are eligible for additional help
- The patient will pay a share of the cost of prescriptions in addition to the monthly premium. The actual amount will vary depending on the drug plan.
- People with limited incomes and resources may be eligible for addition help called the "LOW-INCOME SUBSIDY".
- Plans are available now
- You will be able to choose from several plans
- If you want to stay with your local pharmacy, choose a plan it will accept
- If you currently have drug coverage from an employer or union plan you will receive notice from the plan telling you if the coverage you have is as good as or better than the Medicare plan, or not as good as the Medicare plan. That notice will tell you of the choices available to you
- Even if you don't use a lot of prescription drugs you should consider enrolling in a Medicare prescription drug plan, as you may need prescriptions later. A later enrollment may mean you will pay a higher premium.

This is a very brief introduction to the new Medicare Prescription Drug Benefit but it should start you to think about this new benefit. It is an important addition to Medicare and most people will find it will be very helpful. Please call Senior Health Insurance Counseling in the North Dakota Insurance Department if you have questions at 1-888-575-6611 or www.medicare.gov or 1-800-633-4227.

Social Security Administration reports on Medicare Part D Benefits:

Recently, Congress passed the Medicare Modernization Act. Part of this

legislation provides for a new prescription drug benefit (commonly referred to as Medicare Part D) to be available beginning with January 1st, 2006. In passing this legislation, Congress realized that certain individuals may need some financial help in paying this benefit. The Social Security Administration (SSA) has been tasked by Congress to take and process applications for this help. SSA will use this application to determine if you are eligible for extra financial help to pay for the annual deductible, premiums and any co-payments for the new Medicare Prescription Drug benefit (Medicare Part D). Individuals who receive this information should complete this application and mail it back to Social Security in the provided postage-paid envelope.

It is important to note that this application will not enroll you in the new prescription drug benefit (Medicare Part D). For more information, contact: www.socialsecurity.gov or 1-800-772-1213 or Region 1's local office at 572-0682.

ND Family Caregiver Support Program

Caregiver Stress and Elder Abuse

Article submitted by Michelle Sletvold- NDFCSP Coordinator, Region VIII

As I become more and more familiar with my position, one of the most beneficial aspects of my responsibilities is meeting with caregivers in their homes to see first hand what each caregiver is coping with on a daily basis. Last month, I went into the home of a caregiver to complete the annual reassessment. Unfortunately the care recipients Alzheimer's Disease had progressed and he was exhibiting signs of verbal abuse toward unfamiliar faces as well as his wife and respite providers. I was most impressed with the caregiver's patience. As I sat there and visited with her I noticed how irritated he was at me for being there and she stayed calm, cool, and collected throughout my stay. But how much verbal abuse can she put up with and how long will her tolerance stay intact? His condition is getting worse and eventually the need for placement in the nursing home is likely. Until then, she continues to provide care for him and allow respite care providers to come in and relieve her so she can "relax" and avoid burnout and reduce her stress.

Most caregivers cope effectively, but reports of abuse by stressed caregivers are increasing. This being said I would like to share some "red flags" to watch for and also what can be done to reduce the risk of abuse.

Red Flags for Caregiver:

1. Fears of care recipient becoming violent
2. Suffers from low self esteem
3. Perceives that he/she is not receiving adequate help or support from others
4. Views caregiving as a burden
5. Experiences emotional and mental "burnout", anxiety or severe depression
6. Feels "caught in the middle" by providing care to children and elderly family members at the same time.
7. Has "old anger" toward the care recipient based on their relationship in the past.

Red Flags for the Care Receiver:

1. Is aggressive or combative
2. Is verbally abusive
3. Exhibits disturbing behaviors such as sexual "acting out" or embarrassing public displays

Reducing the risk of elder abuse by caregivers or against caregivers will require efforts of caregivers, agencies and the community.

This is what can be done:

Caregivers can:

1. Get help. Making use of social and support services, including support groups, respite care, home delivered meals, adult day care and assessment services, can reduce the stress associated with abuse.
2. Learn to recognize their ”triggers”, those factors that cause them the greatest stress or anxiety.
3. Learn to recognize and understand the causes of difficult behaviors and techniques for handling them more effectively.
4. Develop relationships with other caregivers. Caregivers with strong emotional support from other caregivers are less likely to report stress or to fear that they will become abusive.
5. Get healthy. Exercise, relaxation, good nutrition and adequate rest have been shown to reduce stress and help caregivers cope.
6. Hire helpers. Attendants, chore workers, homemakers, or personal care attendants can provide assistance with most daily activities. Caregivers who cannot afford to hire helpers may qualify for public assistance.
7. Plan for the future. Careful planning can relieve stress by reducing uncertainty, preserving resources and preventing crisis. A variety of instruments exist to help plan for the future including powers of attorney, advanced directives for health care, trusts and wills.

Agencies can:

1. Carefully screen caregivers and patients for the risk factors associated with caregiver abuse.
2. Provide caregivers with information and support to lower their risk.
3. Provide instruction to caregivers (through materials, classes, websites or support groups) in conflict resolution and how to deal with difficult behavior such as violence, combativeness and verbal abuse.
4. Promote better coordination between agencies that offer protection to victims and those that offer services to caregivers. This can be achieved through cross- disciplinary training, interagency protocols and multi-disciplinary teams.

We, as concerned citizens can:

1. Lend a hand to a caregiver who needs help.
2. Report abuse. In most communities, Adult Protective Services is the agency that accepts and investigates reports.
3. Advocate for public policy to increase the supply and scope of services available to caregivers.
4. Volunteers can make friendly visits, serve as guardians or bill payers, or provide respite care.
5. Arrange to have speakers make presentations on caregiving at churches, clubs or civic organizations.

If you are a caregiver caring for a loved one 60 years of age and older or a Grandparent/Relative raising grandchildren, the ND Family Caregiver Support Program may be able to help. Services include: Respite Care, Caregiver Training, Counseling, Caregiver Support Groups, and Information and Assistance.

The ND Family Caregiver Support Program is available statewide – contact Karen Quick in Region 1 at 774-4685 or 1-800-231-7724.

Information for this article was provided by Institute on Aging for the National Center on Elder Abuse.

Title III of the Older Americans Act
Grants for State and Community Programs on Aging

When President Johnson signed the bill creating the Older Americans Act (OAA) on July 14, 1965, he said: "The Older Americans Act clearly affirms our Nation's sense of responsibility toward the well-being of all of our older citizens. But even more, the results of this act will help us to expand our opportunities for enriching the lives of our citizens in this country, now and in the years to come."

Created during a time of rising societal concerns for the poor and disadvantaged, the OAA set forth a broad set of objectives which are as relevant today as they were over three decades ago. The OAA has been reauthorized 14 times since 1965.

The largest program under the OAA, this title lays out responsibilities and requirements for State and Area Agencies on Aging. In North Dakota, the Department of Human Services, Aging Services Division carries out the responsibilities of both the State and Area Agency. It is through the programs and structures established by this title that most of the money is authorized and most of the legislative detail is found.

The purpose of this title is to encourage and assist the State/Area Agency on Aging to foster the development and implementation of comprehensive and coordinated systems to serve older individuals. This part sets forth authorization levels and details the formula by which AoA funds are allotted to states. For the most part this formula is based on the number of people aged 60+ in each state.

Services

Access services: transportation, outreach, I&A and case management.

In-home services: homemaker, home health aide, visiting and telephone reassurance, chore and supportive services for families of older individuals with Alzheimer's disease and other related disorders.

Legal assistance: financial, insurance and tax counseling, representation in guardianship proceedings.

For a state to participate under Title III, the governor must designate a state agency as the sole agency to put forth a plan for developing and implementing a statewide aging program. This multi-year plan (2, 3, or 4 years) represents a "legal contract" between the state and the federal government for carrying out the programs authorized under the OAA. Like its counterpart at the federal level, the state agency is responsible for serving as an effective and visible advocate for the elderly.

And it must provide assurances that preference will be given to providing services to older individuals with the greatest economic and social need, with particular attention to low-income minority older individuals and older individuals residing in rural areas.

The State/Area Agency is responsible for assessing the needs of older persons within their respective Planning and Service Area (PSA). The State/Area Agency is required to provide assurances that an adequate proportion of funds allocated to the PSA under Title III-B will be expended for the delivery of each of the following categories of services: access, in-home and legal assistance. The Area Agency must establish an advisory council consisting of older

persons (including older minority individuals) who are participants or who are eligible to participate in OAA programs to advise the agency on area plan development, administration and operation.

Part B - Supportive Services and Senior Centers

The justification for the genesis and subsequent evolution of the aging network rests in the belief that there were gaps in the provision of social services for the elderly. The Older Americans Act, and more specifically Title III, is the only federal supportive services program directed solely toward improving the lives of older people. Under current law, all service providers funded under part B must follow priorities established by the State/Area Agency for serving the rural elderly, those with greatest economic and social need including specific objectives for low-income minority older persons. By and large, the list of supportive services funded under Title III has remained fairly constant over the years.

Supportive Services

- Health (including mental health)
- Transportation
- Information and assistance
- Housing
- Long-term care
- Legal assistance
- Services to encourage employment of older workers
- Crime prevention

Part C - Congregate and Home Delivered Nutrition Services:

Millions of older adults are malnourished. Adequate nutrition is necessary to maintain cognitive and physical functioning, to reduce or delay chronic disease and disease-related disability, and to sustain a good quality of life. The OAA provides for the establishment and operation of nutrition projects both in a congregate setting and for homebound individuals. All meals must meet the requirements for the one-third daily-recommended dietary allowances. But the nutrition program is more than a meal. It provides nutrition education, counseling and screening, and often is the gateway to many other services. The law provides that the programs serve at least one hot, cold, frozen, dried, canned or supplemental food meal per day, five or more days a week except in a rural area where such frequency is not feasible. Congregate meals are served in senior centers, schools, churches and other community settings. For many older persons the meal provides not only an opportunity for socialization, but also the only meal that person may have that day.

Part D - Disease Prevention and Health Promotion Services

According to the World Health Organization, health promotion is the process of enabling people to increase control over, and to improve their health.

Disease Prevention and Health Promotion Services

- Health risk assessments
- Routine health screening
- Nutritional counseling and education
- Health promotion programs
- Exercise and fitness programs
- Home injury control services
- Screening for prevention of depression
- Medication management education
- Information concerning diagnosis, prevention, treatment and rehabilitation of age-related diseases and conditions
- Gerontological counseling
- Counseling regarding Social Services

Disease prevention covers measures not only to prevent the occurrence of disease, but also to arrest its progress and reduce its consequences once established. Under this part, the State Unit on Aging (SUA) is required to provide disease prevention and health promotion services and information at senior centers, meal sites and other appropriate locations. They must give priority, in carrying out this part, to areas of the State which are medically underserved and in which there are a large number of older individuals who have the greatest economic need for such services.

Part E - National Family Caregiver Support Program

The enactment of the Older Americans Act Amendments of 2000 (Public Law 106-501) established an important new program, the National Family Caregiver Support Program (NFCSP).

Eligible Population

- Family caregivers of older adults;
- Grandparents and relative caregivers of children not more than 18 years of age (including grandparents who are sole caregivers of grandchildren and those individuals who are affected by mental retardation or who have developmental disabilities).

The program was modeled after several successful state long term care programs and after listening to the needs expressed by hundreds of family caregivers in discussions held across the country.

The NFCSP calls for all states, working in partnership with area agencies on aging and local community-service providers to have five basic services for family caregivers:

- Information to caregivers about available services;
- Assistance to caregivers in gaining access to supportive services;
- Individual counseling, organization of support groups, and caregiver training to caregivers to assist the caregivers in making decisions and solving problems relating to their caregiving roles;
- Respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and
- Supplemental services, on a limited basis, to complement the care provided by caregivers.

Funds are allocated to states through a congressionally mandated formula that is based on a proportionate share of the 70+ population. The statute requires states to give priority

consideration to: 1) persons in greatest social and economic need (with particular attention to low-income individuals); and 2) older individuals providing care and support to persons with mental retardation and related developmental disabilities.

Healthy Aging for Older Adults

The United States is on the brink of a longevity revolution. By 2030, the number of older Americans will have more than doubled to 70 million, or one in every five Americans. The growing number and proportion of older adults places increasing demands on the public health system and on medical and social services.

Chronic diseases exact a particularly heavy health and economic burden on older adults due to associated long-term illness, diminished quality of life, and greatly increased health care costs. Although the risk of disease and disability clearly increases with advancing age, poor health is not an inevitable consequence of aging.

Much of the illness, disability, and death associated with chronic disease are avoidable through known prevention measures. Key measures include practicing a healthy lifestyle (e.g., regular physical activity, healthy eating, and avoiding tobacco use) and the use of early detection practices (e.g., screening for breast, cervical, and colorectal cancers, diabetes and its complications, and depression).

Critical knowledge gaps exist for responding to the health needs of older adults. For chronic diseases and conditions such as Alzheimer's disease, arthritis, depression, psychiatric disorders, osteoporosis, Parkinson's disease, and urinary incontinence, much remains to be learned about their distribution in the population, associated risk factors, and effective measures to prevent or delay their onset.

Source: US Dept. Health and Human Services
Center for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

ND Family Caregiver Support Program

CAREGIVER SURVIVOR TIPS

Being a caregiver can be a very rewarding and loving experience. It can also be a challenging and isolating experience. The process of becoming a caregiver can be a gradual transition; such as someone who is caring for a person with a debilitating disease such as Parkinson's Disease or Alzheimer's Disease. Some can be quickly thrown into the role of caregiver when their relative suffers a stroke or is injured in a fall or car accident.

Regardless of how a person becomes a caregiver, some of the challenges may be the same. Probably the biggest challenge would be a change in lifestyle. Many caregivers find the biggest change is to lose the spontaneity of life. They are not able to make a quick trip to the grocery store or go to lunch with friends on the spur of the moment because they are not able to leave their relative home alone. Some caregivers choose to give up their activities outside the home because it becomes too difficult to make arrangements for help. Others may not know whom to turn to or may lack the financial resources to pay for respite services in the home.

Feelings that can come from being a caregiver are stress, frustration, depression, grief and isolation. Individuals may need to consider counseling services to help cope with the challenges of caregiving. Caregivers tend to ignore their own health needs and there can be times when they are not able to get the rest they need. Caregivers will sacrifice themselves to provide the care to their loved one. Asking or receiving help can be difficult for caregivers. Some caregivers view asking for help as a sign of failure, that they "can't do it all".

In spite of all these experiences, most caregivers feel good about their commitment to keep their relative at home and express little regret about their choice to become a caregiver.

The following are **Caregiver Survival Tips** to help cope with caregiver challenges:

1. **Plan Ahead**: Make a list of available resources in case of need. Such as phone numbers for: local hospital, personal physician, ambulance service, pharmacist, church/pastor, relatives or neighbors you can count on, Poison Control Center, Suicide Prevention/Crisis Intervention Centers, Mental Health Hotline, Police or Fire Department. Practice escape routes from various locations out of your home with your relative in case of an emergency. Get training in CPR.

2. **Learn About Available Resources**: Learn about available services in your community: home care service, home delivered meal programs, senior centers, Public Health or Parish Nursing, Senior Companion Program, transportation services, adult day programs, housekeeping/laundry services, chore services, respite services, emergency call systems, home medical equipment, etc. Information about service in every community can be obtained through the ND Senior Info Line

3. **Take One Day at a Time**: Learn to set realistic goals for yourself. You don't have to be a "Super Woman" or "Super Man". Learn to let go of the less important tasks in life. Recognize and accept your emotions. Don't be afraid to laugh or cry. When possible, break up caregiving tasks into segments. Seek out support groups to share similar experiences with others.

4. **Develop a Contingency Plan**: Make a plan for what to do if something happens to you. Find out if friends or family are available on short notice. Discuss your plan with people who can help put the plan in action. Consider resources available for emergencies, such as: home health agencies, swing bed units, nursing homes, adult foster care homes, adult day programs. Check out options ahead of time and learn the application process required. Don't wait for a crisis to make your plan.

5. **Accept Help**: Make "HELP LIST" of tasks that would be helpful to you. Let people choose from the list when they offer help. Allow yourself to accept help. Allow yourself to ask for help. Accept that you do not have to "do it all."

6. **Make Your Health a Priority:** See the doctor when needed. Take your medications as prescribed. Get help for your relative's personal care if it is too much for you to handle alone.

Get training on proper care techniques or equipment use for lifting or transferring. Put healthy activities into your daily routine.

7. **Get Enough Rest and Eat Properly:** Recharge your own batteries. Consider hiring help if getting enough sleep is a challenge. Use respite care for breaks from being a caregiver: in-home care services, swing bed care, foster care, or day care. Nap when your relative is safe. Eat healthy. Use home delivered meals to make it easy on you.

8. **Take Time for Leisure:** Learn about available respite care. Take brief breaks as able to do something you enjoy: read a book, take a bath, walk around the block, a trip to the beauty shop, quiet time alone, learn to meditate, get a massage.

9. **Be Good to Yourself:** Do activities that make you feel good: listen to your favorite music, read your favorite books, watch a movie, call someone who can make you laugh. Learn to give yourself credit and a pat on the back for the great work you are doing.

10. **Share Your Feelings With Others:** Invite a friend over for coffee. Call a friend. Join a support group. Join a church group. Seek counseling. Get involved with senior center activities. Talk with family.

Maybe you are not a caregiver, but know someone in the community who is. You may ask yourself what can you do to help. The best thing to do is ask the caregiver. Offer to help out in ways that you are comfortable with: car rides, help around the house/yard, meet for coffee, bring in a meal, weekly phone call, simply sit and visit. You may have to offer more than once, but don't give up. Keep in touch. It is very important to be there just to listen.

Article submitted by: **Judy Tschider, Coordinator – ND Family Caregiver Support Program, WCHSC**

The ND Family Caregiver Support Program is available statewide –
Contact Karen Quick in Region 1 – 774-4685 or 1-800-231-7724

Medicare Prescription Drug Coverage Basics

What are Medicare prescription drug plans?

Beginning January 1, 2006, prescription drug coverage will be available to all Americans with Medicare. Every person with Medicare, no matter how they get their health care today or whether they have existing drug coverage will be eligible for drug coverage under a Medicare prescription drug plan. Insurance companies and other private companies will work with Medicare to offer these drug plans. Medicare prescription drug plans will be available in every part of the country, and all plans will cover both brand name and generic drugs.

Medicare prescription drug plans provide insurance coverage for prescription drugs. Like other insurance, if people with Medicare join they will pay a monthly premium (generally around $37 in 2006) and pay a share of the cost of their prescriptions. Costs will vary depending on the drug plan that is chosen.

Drug plans may vary in what prescription drugs are covered, how much someone has to pay, and which pharmacies can be used. All drug plans will have to provide at least a minimum standard level of coverage, which Medicare will set. However, some plans might offer more coverage and additional

drugs for a higher monthly premium. When a person with Medicare joins a drug plan, it is important for them to choose one that meets their prescription drug needs.

A person in a Medicare prescription drug plan that covers the minimum standard would expect to pay a $250 deductible and then 25 percent of their drug costs up to an out-of-pocket limit of $2,250. Medicare drug coverage includes coverage which begins when a person with Medicare drug coverage spends $3,600 for covered drugs in a year. Once this level is reached, the person pays only 5 percent of their drug costs. Again, some plans will offer additional coverage; this is a description of the minimum that must be offered.

When can people with Medicare join the Medicare prescription drug plans?

Those people who have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. If they join by December 31, 2005, their Medicare prescription drug plan coverage will begin on January 1, 2006. If they join after that, their coverage will become effective the first day of the month after the month they join. In general, they can join or change plans once each year between November 15 and December 31.

Everyone should join a plan. Even if someone doesn't use a lot of prescription drugs now, they still should consider joining a plan. If they don't join a plan by May 15, 2006, and don't have a drug plan that covers as much or more than a Medicare prescription drug plan, they will have to pay more if they decide to join later.

Is there additional assistance for those who need it?

People who qualify for extra help paying for Medicare prescription drug costs will get continuous coverage with a small out of pocket cost. The amount they pay out of pocket depends on their income and resources. A beneficiary with limited income and resources who enrolls in a prescription drug coverage plan and qualifies for the most generous help will have more than 95 percent of their drug costs covered. Certain low-income beneficiaries will automatically qualify for the additional help and then will enroll in a prescription drug plan during the regular enrollment period beginning November 15.

Do Medicare prescription drug plans work with all types of Medicare health plans?

Yes. Medicare prescription drug coverage will be offered by many Medicare Health Plans (Medicare Advantage Plans and Medicare Cost Plans) and by stand alone Medicare Prescription Drug Plans. People in the Original Medicare Plan will need to enroll in a Medicare Prescription Drug Plan **(P-D-P)** to get drug coverage.

What if someone already has prescription drug coverage from a Medigap (Supplemental Insurance) Policy?

Those who have a Medigap policy with drug coverage will get a detailed notice from their insurance company telling them whether or not their prescription drug coverage is generally at least as good as standard Medicare prescription drug coverage. If their Medigap coverage is at least as good as Medicare's coverage, if they decide to keep their current drug coverage, they may be able to buy a Medicare prescription drug plan later without having to pay a higher premium. However, most Medigap prescription drug coverage is not at least as good as Medicare prescription drug coverage.

What if someone has prescription drug coverage from an employer or union?

Those who have prescription drug coverage from an employer or union will get a notice from their employer or union that tells them if their coverage is generally at least as good as standard Medicare prescription drug coverage.

If the employer or union plan covers as much as or more than a Medicare

PDP the person with Medicare can…

• keep their current drug plan. If they join a Medicare prescription drug plan later their monthly premium won't be higher (no surcharge), or
• drop their current drug plan and join a Medicare prescription drug plan, but they may not be able to get their employer or union drug plan back.

If the employer or union plan covers less than a Medicare PDP the person with Medicare can…

• keep their current drug plan and join a Medicare prescription drug plan to give them more complete prescription drug coverage, or
• just keep their current drug plan. But, if they join a Medicare prescription drug plan later, they will have to pay at least 1% more for every month they waited to enroll after May 15, 2006, or
• drop their current drug plan and join a Medicare prescription drug plan, but they may not be able to get their employer or union drug plan back.

What effect will the Medicare PDP have on beneficiaries who are food stamp and HUD recipients?

Food stamp and HUD recipients who qualify for extra help paying for a Medicare prescription drug plan will be better off enrolling in a Medicare prescription drug plan, even if this new coverage reduces their food stamp or HUD benefits. They will get significantly more help and protection in drug coverage than they will lose from the reduction in food stamps or HUD.

What effect will the PDP have on beneficiaries who get help with heating/cooling expenses through the Low Income Home Energy Assistance Program (LIHEAP)?

They will not lose their energy assistance. States set eligibility levels for home energy assistance based on your income without regard to your medical expenses.
http://new.cms.hhs.gov/NationalMedicareYouTrain/07_Medicare%20Prescription%20Drug%20Coverage%20Outreach%20Tooklit.asp - outreach toolkit for community-level organizations to provide clear, accurate information and assistance to their clients on the Medicare prescription drug coverage

BASICS FOR HANDLING FOOD SAFELY

(Taken from USDA Food Safety Education; USDA.gov and the FDA)

Safe steps in food handling, cooking, and storage are essential to prevent foodborne illness. You can't see, smell, or taste harmful bacteria that may cause illness. In every step of food preparation, follow the four Fight BAC!™ guidelines to keep food safe:

Clean -- Wash hands and surfaces often.
Separate -- Don't cross-contaminate.
Cook -- Cook to proper temperatures.
Chill -- Refrigerate promptly.

Shopping

Purchase refrigerated or frozen items after selecting your non-perishables.
Never choose meat or poultry in packaging that is torn or leaking.
Do not buy food past "Sell-By," "Use-By," or other expiration dates.

Storage

Always refrigerate perishable food within 2 hours (1 hour when the temperature is above 90 °F).
Check the temperature of your refrigerator and freezer with an appliance thermometer. The refrigerator should be at 40 °F or below and the freezer at 0 °F or below.

Cook or freeze fresh poultry, fish, ground meats, and variety meats within 2 days; other beef, veal, lamb, or pork, within 3 to 5 days.

Preparation

Always wash hands before and after handling food.

Don't cross-contaminate. Keep raw meat, poultry, fish, and their juices away from other food. After cutting raw meats, wash hands, cutting board, knife, and counter tops with hot, soapy water.

Marinate meat and poultry in a covered dish in the refrigerator.

Sanitize cutting boards by using a solution of 1 teaspoon chlorine bleach in 1 quart of water.

Storage:

Perishable food such as meat and poultry should be wrapped securely to maintain quality and to prevent meat juices from getting onto other food.

To maintain quality when freezing meat and poultry in its original package, wrap the package again with foil or plastic wrap that is recommended for the freezer.

In general, high-acid canned food such as tomatoes, grapefruit, and pineapple can be stored on the shelf for 12 to 18 months. Low-acid canned food such as meat, poultry, fish, and most vegetables will keep 2 to 5 years -- if the can remains in good condition and has been stored in a cool, clean, and dry place. Discard cans that are dented, leaking, bulging, or rusted.

Leftovers

Discard any food left out at room temperature for more than 2 hours (1 hour if the temperature was above 90 °F).

Place food into shallow containers and immediately put in the refrigerator or freezer for rapid cooling.

Use cooked leftovers within 4 days.

Refreezing

Meat and poultry defrosted in the refrigerator may be refrozen before or after cooking. If thawed by other methods, cook before refreezing.

NUTRITION NEWS: www.cdc.gov/ncidod/diseases/food/safety.htm - preventing the spread of salmonella and other food-borne illnesses and www.mypyramid.gov - USDA food guidance system

ND Family Caregiver Support Program

Grandparents Raising Grandchildren

They are being called the “unsung heroes and heroines of the 21st century.” They are the grandparents parenting the next generation, a responsibility that often proves to be long term. Grandparents raising grandchildren is not a new phenomenon, but Census 2000 data indicate

there has been a dramatic increase in the role of grandparents raising grandchildren in the past decade. Other data show that:

- More than 2.4 million grandparents are responsible for grandchildren nationally. There are 2,547 grandparent caregivers in North Dakota.
- Across the country, more than 6 million or approximately one in 12 children younger than 18 are living in households headed by a relative other than the parent; 4.5 million of these children are living with grandparents.
- Throughout North Dakota, nearly 5,000 or approximately one in 33 children are living in households headed by a relative other than a parent. The majority is living with grandparents (3,901 or 2.4 percent of all children in North Dakota).
- Cultural considerations also come into play. Children living on Native American reservations in North Dakota are five to eight times more likely to live in grandparent-headed households than the state average.
- Children who live in grandparent-headed households are at the greatest risk of not being covered by health insurance and are at a higher risk of being in poverty.

Changes and Challenges

Factors contributing to changes in family composition:

*Parental substance abuse
*Mental or physical illness or disability
*Child abuse, neglect or family violence
*Unexpected pregnancy of teen or adult child
*Military deployment
*Divorce or death of a parent
*Arrest or incarceration
*Abandonment of grandchild
*Unemployment and poverty

Challenges for grandparent caregivers:

*Lack of legal custody or guardianship
*Declining health and stamina
*Intimidated or frustrated by the eligibility requirements for financial support
*Financial strain
*Limited time and money
*Unaware of or unfamiliar with accessing community resources
*Role and relationship changes
*Lack of housing/space

North Dakota Study of Grandparents Raising Grandchildren

In 2002, the North Dakota State Data Center conducted a study of informal caregiving in North Dakota, including grandparents raising grandchildren. A special focus on caregivers living on Native American reservations was conducted separately. Researchers completed a series of phone and face-to-face interviews with grandparents across the state to identify barriers and difficulties grandparents experience in providing care to grandchildren in North Dakota. To learn more about the study and view the complete report, visit: **www.ndkidscount.org/family/grandparentcaregivers.htm**. Key findings from the study include:

- Overall, grandparents accepted the responsibility of their caregiving role without identifying serious difficulties or concerns. However, their three biggest concerns were emotional aspects (25%), the financial burden (25%), and feeling tied down (25%).

- At least three-fourths of grandparents indicated that school lunch programs (88%), extracurricular activities (82%), and special education (76%), were services available to their grandchildren. For at least one-fourth of grandparents, mentoring programs (27%), tutoring (28%), and scholarships (30%) were not available.
- Half of grandparents said they had access to information on services (55%). However, half said shopping assistance (49%) and parish nurses (56%) were not available to them.

(Reprinted with permission from North Dakota Kids Count, Vol. 3, No. 3)

Support for North Dakota Grandparent Caregivers

- In North Dakota, relatives are the first option for out-of-the-home placement of children.
- Each county social services office offers counseling, referrals and other support to grandparents or relatives caring for children.
- Relatives must meet the same licensing standards established for non-relative foster parents in order to receive any payment for care.
- In addition, North Dakota offers a subsidized guardianship program to relatives caring for children between the ages of 12 and 18, after they have obtained guardianship from the court. This subsidy is also available to children under 12 if they are part of a sibling group, or children over 18 still in school.
- Research shows that as many as half (52%) of North Dakota grandparent caregivers are not legal guardians of their grandchildren and thus would not qualify for subsidized guardianship.

Services Available to Grandparent Caregivers in North Dakota

County social services offices are the first point of contact for families who need economic assistance, child welfare services, supportive services for elderly or disabled individuals, children's special health services, or need help locating other local resources. If the caregiver is age 60+ and providing care for a child 18 and/or younger, there may be assistance available from the ND Family Caregiver Support Program. Contact Karen Quick in Region 1 at 774-4685 or 1-800-231-7724. For more information about services in North Dakota, visit: **www.ndkidscount.org/family/grandparentcaregivers.htm**

Grandparent Caregivers and Grandchild Characteristics: 2002 North Dakota Study

- Two-thirds (67%) of grandparent caregivers were younger than 65.
- Half (48%) of grandparent caregivers were employed; one-fourth (26%) were working full-time.
- 71% of grandparent caregivers were married or living with a partner.
- 55% of grandparent caregivers were living in rural areas.
- Two-thirds (63%) of grandparent caregivers had an annual household income of $35,000 or less.
- More than half (57%) of grandparent caregivers cared for just one grandchild.
- Half (47%) of the grandchildren were younger than 10.
- Nearly half (45%) of grandparent caregivers provided around the clock care; 61% had been providing care for their grandchildren for four or more years. It is understandable why one-fourth (25%) of grandparents reported feeling "tied down".
- Of grandparent caregivers who said their grandchild had *special needs* (44%), the top three needs were emotional issues, learning disabilities, and hyperactivity disorders.
- One-fourth (27%) of grandparent caregivers estimated spending more than $5,000 per year caring for their grandchild; one-fourth (25%) did not know how much they had spent.

- Three-fourths (76%) of grandparent caregivers received no monetary compensation for care. Half (46%) indicated that financial support would be valuable to them.
- 59% of grandparent caregivers reported that their grandchildren received no financial assistance.
- One-third of grandparent caregivers received non-monetary compensation through a school lunch program (38%) or through medical assistance (34%).
- 41% of grandparent caregivers reported having no financial difficulties, such as conflicts between work and caregiving, due to caring for their grandchildren.

(Reprinted with permission from North Dakota KIDS COUNT)

MENTORING INFORMATION:
http://www.mentoring.org/program_staff/eep/elements_of_effective_practice_toolkit.php - a comprehensive toolkit - Elements of Effective Practice – step-by-step instructions that programs can follow to implement key 4 components of effective mentoring practice: Program Design and Planning; Program Management; Program Operations; and Program Evaluation.

for Older Americans

Consumer Facts

What You Should Know About Your Credit Report

If you have ever applied for a credit card, a personal loan, insurance, or a job, there is probably a company keeping a credit file or credit report about you. This file contains information about where you live and work, how you pay your bills, or whether you have been sued, arrested, or have filed for bankruptcy.

Companies that gather and sell this information are called “Consumer Reporting Agencies” or “Credit Bureaus”. The information sold by Consumer Reporting Agencies to creditors, employers, insurers, and other businesses is called a “credit report”.

Here are answers to some common questions about credit reports, consumer reporting agencies, and credit scores.

Can I obtain free copies of my credit reports?

Yes. Due to a recent change in the law, you can get a free copy of your credit report once every 12 months from each of the three big nationwide Consumer Reporting Agencies. By September 1, 2005, everyone in the country will have this right.

How do I order my free annual report?

The three nationwide Consumer Reporting Agencies have set up one central website, toll-free telephone number, and mailing address through which you can order your free annual report. To order:

- Click on **www.annualcreditreport.com** or
- Call 877-322-8228, or
- Complete the Annual Credit Report Request form and mail to:
  Annual Credit Report Request Service

PO Box 105281
Atlanta, GA 30348-5281
http://www.ftc.gov/bcp/conline/edcams/freereports/index.html

Do not contact the three nationwide Consumer Reporting Agencies individually for your free annual report. They are only providing free annual credit reports through the three centralized sources listed above.

You may order your free annual reports from each of the three nationwide Consumer Reporting Agencies at the same time, or you can order from only one or two.
The three major credit bureaus are:

Equifax	Experian	Trans Union
800-685-1111	888-EXPERIAN	800-916-8800
www.equifax.com	(888-397-3742)	**www.transunion.com**
	www.experian.com	

What information do I have to provide to get my free copy?

You need to provide your name, address, Social Security number, and date of birth. If you have moved in the last two years, you may have to provide your previous address. To maintain the security of your file, each nationwide Consumer Reporting Agency may ask you for some information that only you would know, like the amount of your monthly mortgage payment. Each agency may ask you for different information.

www.annualcreditreport.com is the only authorized source for your free annual credit report from the three nationwide Consumer Reporting Agencies. **www.annualcreditreport.com** and the nationwide Consumer Reporting Agencies will not call you or send you an e-mail asking for your personal information. If you get a telephone call or an e-mail or see a pop-up ad claiming it's from **www.annualcreditreport.com** or any of the three nationwide Consumer Reporting Agencies, do not reply or click on any link in the message-it's probably a scam. Forward any e-mail that claims to be from **www.annualcreditreport.com** or any of the three Consumer Reporting Agencies to the FTC's database of deceptive spam at **spam@uce.gov**.

Can I obtain other free credit reports?

Yes, in certain circumstances. If your application was denied because of information furnished by the Consumer Reporting Agency, and if you request a copy of your credit report within 60 days of receiving the denial notice, you are entitled to the information without charge. You are also entitled to one free report once in any 12-month period, if you certify in writing that you:

- Are unemployed and intend to apply for a job in the next 60 days;
- Are receiving public welfare assistance; or
- Believe that your report is wrong due to fraud

If you don't meet one of these requirements, the Consumer Reporting Agency may charge a fee, currently up to $9.50 for a copy of your report. In some cases, Consumer Reporting Agencies are required to provide consumers a free report or a report at a reduced fee.

(Reprinted from National Consumer Law Center Inc.)

TRANSPORTATION INFORMATION:

The Easter Seals Disability Services has put together a series of transportation solutions for caregivers. They include a Caregiver Transportation Toolkit and Facilitator Manual, a Solutions Package for Volunteer Transportation Programs, Solutions Package for Adult Day Services Transportation Programs, and Senior Transportation Options Template for Communities. **www.easterseals.com**

http://www.thehartford.com/talkwitholderdrivers/ - family conversations with older drivers

http://www.thehartford.com/alzheimers/ - At the Crossroads – A Guide to Alzheimer's Disease, Dementia and Driving

American Public Transit Association – **www.apta.com**; American Society on Aging – **www.asaging.org/drivewell**; 2 seat device at bus stops – **www.simmeseat.com** and Lane Transit District – **www.ltd.org**

http://www.aoa.gov/prof/transportation/transportation.asp - transportation toolbox

Value of Unpaid Activities by Older Americans Tops $160 Billion Per Year

Many older Americans continue to make valuable contributions to society long after they withdraw from the labor force. Older people often spend time caring for grandchildren and frail family members. Many volunteer their time to church groups, charitable organizations, and cultural institutions. Many also volunteer informally, helping friends and neighbors in need. Because older adults are not generally paid for their help, these services are often overlooked in the ongoing debate about Social Security, possible changes to the retirement age, and the proper role of older Americans in an aging society.

Value of Unpaid Activities

Americans age 55 and older contributed between $97.6 billion and $201 billion to society in 2002 through volunteer activities and time spent caring for family members. Our best estimate values unpaid activities at $161.7 billion, or $2,698 per person. About 74% of older adults volunteered their time or provided unpaid care to family members in 2002. Among just those who volunteered or provided care, the average value of contributions amounted to $3,662.

Time devoted to the care of family members absorbed about 61% of the total value of unpaid activities. The value of this care provided by older adults approached $100 billion, with about two-fifths devoted to spousal care, another two-fifths to grandchild care, and the remaining fifth to parent care. By comparison, the nation spent an estimated $135 billion on formal long-term care services for the aged in 2004.

Older Americans contributed $44.3 billion through formal volunteer activities in 2002, and another $17.8 billion by volunteering their time through informal channels.
(The Retirement Project-Perspectives on Productive Aging: No. 4, September 2005)

VETERAN'S IN-HOME SERVICES: all veterans who are getting primary health care at a VA hospital are eligible for a comprehensive array of medically necessary in-home services. These services may be VA-provided, purchased and/or arranged through a VA medical center. Services may include skilled nursing, social work services, home health services and other personal and support services that enable veterans to safely remain in their home. The VA-physician, as the primary medical doctor, is able to prescribe these services when medically necessary and appropriate to the needs of the veteran. If special equipment is needed in

the home, such as shower benches, grab bars or other adaptive aides, an assessment of need may also be done at the VA medical center and the appropriate equipment prescribed by the primary care provider. For help and information, contact Patty Evans, the extended care and rehabilitation service line site director at the Fargo VA Medical Center at 1-800-410-9723 or 1-701-237-2635.

Telephone Numbers to Know

Regional Aging Services Program Administrators

Region I - Karen Quick
1-800-231-7724
Region II – MariDon Sorum
1-888-470-6968
Region III - Donna Olson
1-888-607-8610
Region IV - Patricia Soli
1-888-256-6742
Region V - Sandy Arends
1-888-342-4900
Region VI - Russ Sunderland
1-800-260-1310
Region VII - Cherry Schmidt
1-888-328-2662 (local 328-8787)
Region VIII - Mark Jesser
1-888-227-7525

Vulnerable Adult Protective Services

Region I & II – Dale Goldade, Vulnerable Adult Protective Services - 1-888-470-6968

Region III – Ava Boknecht, Vulnerable Adult Protective Services, 1-888-607-8610

Region IV - Vulnerable Adult Protective Services – Patricia Soli 1-888-256-6742 or GF CSS 701-787-8540

Region V - Vulnerable Adult Protective Services, Sandy Arends - 1-888-342-4900. Direct referral may be made to Cass County Adult Protective Services unit - 701-241-5747.

Region VI - Russ Sunderland, Vulnerable Adult Protective Services - 701-253-6344

Region VII - Cherry Schmidt or Cherie Denning, Vulnerable Adult Protective Services - 1-888-328-2662 or 701-328-8888

Region VIII - Mark Jesser, Vulnerable Adult Protective Services - 1-888-227-7525

ND Family Caregiver Coordinators

Region I - Karen Quick - 800-231-7724
Region II –Theresa Flagstad - 888-470-6968
Region III - Kim Locker-Helten - 888-607-8610
Region IV - Raeann Johnson - 888-256-6742
Region V – LeAnne Thomas - 888-342-4900
Region VI-CarrieThompson-Widmer -800-260-1310
Region VII - Judy Tschider - 888-328-2662
Region VIII - Michelle Sletvold- 888-227-7525

Other

Aging Services Division and Senior Info Line: 1-800-451-8693

AARP: 1-888-OUR-AARP (1-888-687-2277)

ND Mental Health Association (Local) 701-255-3692/ Help-Line: 1-800-472-2911

IPAT (Assistive Technology): 1-800-265-4728

Legal Services of North Dakota:
1-800-634-5263 or 1-866-621-9886 (age 60+)

Attorney General's Office of Consumer Protection: 701-328-3404 or 1-800-472-2600

Social Security Administration: 1-800-772-1213

Medicare: 1-800-633-4227

Senior Health Insurance Counseling (SHIC) ND Insurance Department: 701-328-2440

Prescription Connection: 1-888-575-6611

Long-Term Care Ombudsman Services

State Ombudsman: Helen Funk-800-451-8693

Region I & II- Dale Goldade-1-888-470-6968

Region III & IV- Kim Locker-Helten or Donna Olson - 1-888-607-8610 or 701-665-2200

Region V & VI- Bryan Fredrickson -1-888-342-4900

Region VII- Helen Funk-1-800-451-8693

Region VIII- Mark Jesser-1-888-227-7525